

US Resolutions Inc.

An Independent Review Organization
3267 Bee Caves Rd, PMB 107-93
Austin, TX 78746
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/14/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
six sessions of left ankle physical therapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Anesthesiologist; Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds the request for six sessions of left ankle physical therapy is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 06/20/12, 07/11/12

Prospective review (M2) response dated 07/25/12

Progress note dated 06/07/12, 07/05/12, 06/12/12, 06/14/12

Patient referral forms various dates

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. Progress note dated 06/07/12 indicates that the patient states she is feeling better overall with good results from PT and her home exercise program. Assessment notes sprain/strain knee/leg other spec sites; sprain/strain ankle, other; and leg laceration. The patient completed 13 sessions of physical therapy. Progress note dated 07/05/12 indicates that the patient reports continued pain in the left ankle. MRI was essentially negative and showed a grade I strain of her ATFL and calcaneofibular ligaments. Knee pain is improved. On physical examination ankle shows no deformity, no ecchymosis and no swelling of the ankle. There is tenderness inferior to the lateral malleolus. Range of motion of the ankle is good. Gait is mildly antalgic. Initial request for six sessions of physical therapy was denied on 06/20/12 noting that the patient has completed a course of physical therapy consistent with the recommendations found in the Official Disability Guidelines and the documentation fails to demonstrate exceptional factors in this case that would justify extended physical therapy 3.5 months status post sprain/strain injury and the physical therapy re-examination fails to outline significant subjective complaints and functional deficits in need of additional skilled physical therapy. The examination

suggests the patient is ready for a self-directed home program. The denial was upheld on appeal dated 07/11/12 noting that the documents provided do not justify the request. The range of motion is normal and at this point formal physical therapy would provide no benefit over a home exercise program. It appears that the patient has now had 13 physical therapy sessions, which exceeds the Official Disability Guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

This patient sustained sprain/strain injuries to the knee and ankle, and has completed 13 physical therapy visits to date. The Official Disability Guidelines support up to 12 visits for the patient's diagnoses, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient's physical examination is grossly unremarkable. ODG would provide for improvement of strength and range of motion with an independent, self-directed home exercise program. Based on the clinical information provided, the reviewer finds the request for six sessions of left ankle physical therapy is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)